H.R. 2833, THE PREEXISTING CONDITION EXCLUSION PATIENT PROTECTION ACT OF 2007

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH,
EMPLOYMENT, LABOR AND PENSIONS

COMMITTEE ON
EDUCATION AND LABOR

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C O N T E N T S

H.R. 2833, THE PREEXISTING CONDITION EXCLUSION PATIENT PROTECTION ACT OF 2007

Thursday, March 20, 2008
U.S. House of Representatives
Subcommittee on Health, Employment, Labor and Pensions
Committee on Education and Labor
Washington, DC

The subcommittee met, pursuant to call, at 2:31 p.m., in hearing room 1-D, Legislative Office Building, 300 Capitol Avenue, Hartford, Connecticut, Hon. Robert Andrews [chairman of the subcommittee] presiding.

Present: Representatives Andrews and Courtney.

Staff Present: Carlos Fenwick, Policy Advisor for Subcommittee on Health, Employment, Labor and Pensions; Sara Lonardo, Junior Legislative Associate, Labor; Ken Serafin, Minority Professional Staff Member.

Chairman ANDREWS. Ladies and gentlemen, the subcommittee will come to order.

Good afternoon. It's my privilege to be here in the undisputable capital city of Connecticut and receive such a warm welcome thus far.

I want to thank you, Congressman Joe Courtney, in arranging for this hearing and inviting us here today.

I have had the privilege of serving in Washington for 18 years now. I was very young when I started. I must tell you I am absolutely weary of theoretical discussions about health care. I am really tired of it. The next person that comes into my office and says we need high quality, affordable and accessible health care, I am going to throw them out of my office because I have heard those three phrases again and again and again. I was tempted to say nothing has changed. That is not true; something has changed. When I was privileged to go to Washington in 1990 we had about 35 million uninsured Americans. Today we have 48 million uninsured Americans. It's changed the wrong way. I made a vow to myself I am going to be rejecting theory, embracing reality.

What we are here to talk about today, my friend Joe Courtney has a very valid based idea of how to deal with the problems of the uninsured. We've done a lot of research on the uninsured. They are uninsured for various reasons and for various periods of time. Some because they run up against lifetime policy limits. There's a lot of belief the remedy to that is to abolish lifetime policy limits. Other people are uninsured because they live in a family where the

wage earner is not employed by an employer who can afford health insurance. We think we had a very good answer for five million of those children in the Children's Renewal Health Insurance Program this year, which had broad Democratic and Republican support. It failed to pass because it was one vote short of the White House. One vote short of the House of Representatives.

The third idea, which is gaining, is because of Joe Courtney's efforts. Americans who lack health insurance because they are unfortunate enough to have a preexisting health condition. By our research there are about 7.2 million Americans as we meet this afternoon who are uninsured because they have a preexisting condition.

Now the law that was passed in 1996 says that those individuals can be made to wait for about a year before they can be brought into a health plan. I want you to focus on these facts. This is a person who has a job, works for an employer who offers health insurance to his or her employees, but has to wait for a year because he or she has a preexisting condition. The idea that Congressman Courtney is championing would take a huge bite out of that problem.

Our quick research indicates that the Courtney idea could result in health care for five million people that presently don't have insurance. This story has a moral dimension and economic dimensions. The moral dimension is obvious in a country as large as this one, a person who has breast cancer, diabetes, HIV or some other condition and is not able to get health care coverage because of some arbitrary waiting period, it is outrageous and needs to be fixed.

Beyond that there is the economic dimension. How much longer are we going to be able to sustain a health care system where so many people are uninsured but receive health care anyway. Uninsured people thank goodness, do get health care in emergency rooms or other settings. The way we pay for it is irrational. It is a drain on the employees, the employer and the economy. We need a system where more people get health care coverage not only morally, but the way we pay for it. So Congressman Courtney made a very constructive, in my view pragmatic suggestion how to address this problem.

As the person privileged to be the chairman of the subcommittee with jurisdiction over this area, I am very enthusiastic about this idea. I think under the circumstances this kind of idea can reach out across the political hill, both Democrats and Republicans, and get the job done. The purpose of this hearing is to educate the members of subcommittee and members at large as to the progress we were to make if we were to take Congressman Courtney's idea, work with both political parties, get them in the act as soon as we could. I want to thank Joe.

When I was the junior representative, achievement was figuring out how the elevators work. Joe has far exceeded that level of achievement. He is a problem solver. I serve with him on the Armed Services Committee and he has had an impact. I serve with him on the Education and Labor Committee. He is a workhorse, not a show horse. He's one of the members that comes early, stays for the duration, asks very probing questions and substantive questions, participates in the deliberations of the committee in a

thoughtful and constructive way. When he extended the invitation, I accepted. I would thank him for that and ask for an opening statement.

Mr. COURTNEY. I have no way to go but downhill. I want to welcome you to Connecticut, Rob, and for coming to Hartford today.

He's got a busy schedule back home in New Jersey. It is exciting for me to be back in my old stomping grounds. I have lots of friends in the Legislative Office Building to welcome Rob. As someone who does serve on both of my committees with Rob, he's without a doubt one of the brightest, most effective members of Congress. I had the pleasure to get to know him over the last year or so. Just a couple of weeks ago Rob actually was on the floor managing passage in the house of the Paul Wellstone Mental Health Parity bill which was a watershed for this country. It put the U.S. House of Representatives to a first time majority vote for a simple, but important concept for this country which is mental illnesses. Nervous conditions will be treated exactly the same way as any other physical ailment that people suffer from. And it was not an easy debate that was on the floor. It was a very hotly contested issue. It was again a lot of arguments that were thrown against the bill from the opposition and Rob did a masterful job in terms of guiding this legislation through.

It was during the course of the debate with Senator Kennedy and son Patrick were sitting on the floor a few feet away to sort of be there for this moment which many people in this country have been waiting for for an extremely long period of time. He successfully guided the debate all the way to passage.

If we look back at the 110th Congress sometime down the line, I think what Congressman Andrews did in terms of getting passage of the mental health bill would be one of the high moments of the new congress.

I again want to say it is great to be with a lot of good friends like my friend Edith Prague who I served together with on the Public Health Committee and Human Services Committee for many years. She's been a tireless advocate on health care and quality, doing good things at the State level and so many others in the room.

As Congressman Andrews said, this bill is focused on what I think is the very sort of practical, real issue in terms of our health care system, also on the work lives of millions of Americans, which is in a country where the largest number of people with insurance get it through their employment.

The question of how to make a system that works for people moving from employment-based health coverage to a new occupation, which is something that happens all the time in a very dynamic economy like the U.S. economy, that we have a system that actually works for people, so that when they make what is sometimes necessary decisions because of layoff or because of change in circumstances or because they want to advance themselves and their families, they don't put at risk critical health coverage that they or their children or their spouses depend on in many cases to receive lifesaving health care access and cure.

In 1996 the Congress passed again another watershed piece of legislation, the Health Insurance Portability and Access Act. Again

there was a struggle to get that legislation through. In retrospect HIPAA, as it's called, is an inefficient inevitable part of the economic and health care landscape. That didn't just happen, it took a lot of hard work and advocacy for people to set up the basic structure of portability which provides guaranteed coverage for individuals subject to some preexisting condition exclusions.

People are moving from one group health plan to another. We now have 12 years of experience under our belts as a country to look at how this is operated and to determine whether or not, like any law, it needs to be updated or modified based on real life empirical conditions that suggests we can do better as a country to make the system work better. That really is what the focus of this legislation is. As Rob indicated we still have a health care system struggling in so many ways. Certainly for the employment-based piece of the system this legislation is aimed at what I think is a real problem. I think some of the testimony and evidence is going to bring out today, again solve a lot of issues for people who want to again advance themselves and their families, but are many times held back because of rules that restrict their access to needed health care.

The line up of witnesses that we have here today is, I think, extremely impressive. I want to thank all of them for taking the time out of their schedule to join us here today. We have a diversity of views we have patient, advocate, insurer prospective payer, etc. All of those points of view need to be listened to as we move forward to try to improve our health care system.

Again I am looking forward to a lot of the testimony which I had a chance to see some of it in advance, certainly open it up for some question and answer.

Thank you very much, Mr. Chairman, in helping us explore this issue.

[The statement of Mr. Courtney follows:]

Prepared Statement of Hon. Joe Courtney, a Representative in Congress From the State of Connecticut

Thank you all for joining us this afternoon. I must say what a pleasure it is to return to Hartford in the LOB. As co-chair of the Public Health Committee in the Connecticut General Assembly in the early 1990s, we tackled many of these issues and it is my privilege to continue to work on them in Washington, D.C.

Chairman Rob Andrews, and the Committee on Education and Labor, thank you for traveling to Connecticut to explore improving access to health insurance for the nearly one third of the American population with at least one chronic or pre-existing medical condition, or an estimated 1,114,538 Connecticut residents.

I would like to extend my appreciation to our panel of witnesses who have come today to share their personal stories, experience and expertise on the subject.

As you may be aware, Connecticut tends to be ahead of the nation when it comes to quality health care access. For example, the Congress just passed mental health parity this past month, but parity has been law in Connecticut since 1999 (PA 99-284; "An Act Concerning Managed Care Accountability"). But when it comes to allowing access to coverage for individuals, even with the most minor preexisting condition, Connecticut falls behind with the rest of the nation.

What we will explore today is the length of time that individuals are forced to go without coverage, how deep into their medical records health insurance companies are allowed to poke around and whether or not people who need coverage can access it or are required to pay twice as much to join a state high risk pool. We are answering a fundamental question—is health insurance about avoiding risk or pooling risk?

For me, the answer is clear. Health insurance is a means to pool risk so that all individuals can access health coverage that goes beyond emergency room visits.

That is why I introduced the "Pre-existing Condition Exclusion Patient Protection Act of 2007" (H.R. 2833) to pool risk to ensure that individuals who suffer from chronic, disabling, and life-threatening conditions have access to comprehensive, meaningful and affordable health insurance coverage.

For more than a decade, the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) has provided important protections to individuals and families when they change health plans due to job-related or other transitions. HIPAA was designed to help guarantee the availability and renewal of health insurance coverage by restricting the circumstances under which pre-existing condition limitations can be applied to private insurance beneficiaries. Yet, significant gaps in the laws hamper an individuals' access to care due to a pre-existing medical condition.

This legislation aims to limit the gaps in the HIPAA coverage by (1) shortening the amount of time during which an employer could exclude coverage for pre-existing conditions from 12 months to three months. Currently, individuals with pre-existing conditions as of a 63-day break in coverage eliminates any prior creditable coverage, thereby allowing an employer to exclude coverage for pre-existing conditions for up to 12 months. This decrease in the number of months in which an individual is unable to obtain health insurance would ensure that more Americans receive the health care coverage they need and that the law is consistent with the requirements for "state-qualified plans" under the Trade Adjustment Assistance Reform Act of 2002.

The legislation also (2) shrinks the permitted "look-back" period from six months to 30 days, thereby reducing the number of individuals who are caught in the pre-existing condition web. Currently, employers can restrict coverage for pre-existing conditions based on a six-month "look-back" period. When medical recommendations, diagnoses, and treatments occur during this timeframe, an individual is deemed to have a "pre-existing condition" for the given ailment that was addressed. This "look-back" period is sufficiently long that it likely impacts all Americans with at least one chronic illness—one out of every three Americans.

Finally, it will (3) apply the same pre-existing condition protections afforded to individuals in the group health insurance market under HIPAA to individuals moving to, and within, the individual health insurance market. Let me be clear, the legislation does not mandate that insurance companies uniformly accept every individual for coverage. It simply says that individuals who would not be subject to pre-existing condition exclusion in the group market as a result of having prior credible coverage for over 18 months should not be subject to a rider or be denied coverage in the individual market.

According to the Small Business Administration, there were an estimated total of 347,600 small businesses in Connecticut in 2007. As the number of sole proprietors and small businesses grow, those employers and their employees need to be able to access complete health insurance. The ability to provide employees with health insurance is critical to the ability of these companies to recruit employees and be competitive in the marketplace. In the National Federation of Independent Businesses' "Principles of Health Care Reform," the concept of portability is one of the ten principles. H.R. 2833 will allow for workers to transition between large corporations, and small businesses without fear of loosing health coverage. This levels the playing field between large corporations and small businesses.

This legislation would ensure that the 158 million individuals who are insured through employer-based private plans and the more than 14 million individuals who are covered by non-group, private plans would have far better protection when changing jobs or their health care plans.

H.R. 2833 is aimed at getting at the problem that an individual, whether in the group or individual market faces, when trying to access health insurance. Even the American's Health Insurance Plans, which represents the private insurance companies, has acknowledged the problem by unveiling their proposal. The Guaranteed Access Plans (GAPs) would cover uninsured individuals with potentially high medical costs. It will increase the number of insured by making States responsible, with help from minimal insurers, to extend coverage to the currently deemed 'uninsurable' or rather, those the insurance company deems "unprofitable."

Right now, individuals who qualify for health coverage have no choice but to forgo coverage until the "wait period" is over. Or, they are lucky enough to be covered right away but face a "rider" for an illness or injury, meaning that a specific ailment or treatment will not be covered for a set period of time. The beneficiary will be forced to pay out of pocket for the one thing that they need covered the most.

For individuals who are denied coverage, even the insurance of last resort has a waiting period. Many states maintain a high risk pool, such as the Connecticut Health ReInsurance Association. In Connecticut, the individual must first satisfy all

the criteria under HIPAA, including having 18 months of credible continuous coverage, used up any eligible COBRA and have applied to the pool within 120 days of loosing prior coverage (or 150 days if the loss of prior coverage was due to an involuntary job loss).

If the applicant does not satisfy the HIPAA portability requirements than they are subject to a 12 month waiting period for coverage and a six-month 'look back' period for determining a pre-existing medical condition.

Once the applicant is accepted into a state high risk pool, their premiums will be between 120 to 150 percent higher than the average, standard market rate. In Connecticut, the average cost per enrollee is $3,985 annually just for their premiums. This does not include the thousands in co-pays and additional medical expenses that an individual may be forced to pay out of pocket. That figure is of course supported by the $7,202 that the state must pay annually per enrollee.

High risk pools simply transfer the cost of passing along the cost of insuring individuals with potentially higher medical expenses. The risk is in fact not pooled by the collective insurance community but passed along to the taxpayers.

Once again, I would like to thank the committee and the witnesses for joining us today to explore the role that pre-existing condition exclusion in creating hurdles for accessing health insurance.

Chairman ANDREWS. I am going to introduce the panel of witnesses, ask them to proceed. I will tell the panel their written statements are entered into the record.

I will ask you to summarize your testimony in about five minutes so we can get to some questions and interaction.

Nancy Davenport-Ennis is a cancer survivor and the Founding Executive Director of the National Patient Advocate Foundation. Ms. Davenport-Ennis also established the Patient Advocate Foundation, a direct patient services non-profit organization, in 1996. She serves as a Commissioner on the American Health Information Community to the U.S. Department of Health and Human Services and is a Co-Chair of the AHIC Consumer Empowerment Working Group. Ms. Davenport-Ennis holds a BA in English from Campbell University.

Welcome. We are glad that you're with us.

Rita Gould is a retired professor and diabetes patient who has struggled with finding and keeping health insurance. When she needed to cover a six-month gap between the end of her husband's insurance and the start of her Medicare coverage, she was told that her diabetes was a serious enough pre-existing condition to deny her coverage, even though she had never missed a day of work or been hospitalized because of it. She had done exactly what the rules suggested she was supposed to do. When she finally got coverage through Connecticut's high-risk State pool, the premiums cost $1,300 a month, more than twice what she paid under her husband's plan. She is going to tell the consequence of that story. We are glad she's with us. Frankly, some people may not have such a good outcome. She received her BS from Central Connecticut State University and a MS from the University of Bridgeport.

Welcome, Ms. Gould. I am glad you're with us.

James Stirling is CEO of Stirling Benefits, a third-party administrator of self-insured health plans. Mr. Stirling is also President of the Society of Professional Benefit Administrators and formally served on the Business Advisory Council of the Universal Health Care Foundation of Connecticut. He was secretary of the Connecticut Benefit Brokers from 2002 to 2007 and is a member of the New Haven Health Care Council and Milford Legislative Action

Committee. Mr. Stirling received his BA from the University of Massachusetts Amherst in 1985.

Welcome, Mr. Stirling. We are glad you're with us.

Donna Horoschak—did I pronounce your name correctly?

Ms. HOROSCHAK. Horoschak.

Chairman ANDREWS. Excuse me.

She's Vice President for product policy at America's Health Insurance Plans. Prior to joining AHIP, Ms. Horoschak spent 20 years with Wausau Insurance Companies, including heading up its government affairs department and leading the legal team. She received her undergraduate degree from Southern Illinois University and law her law degree from the University of Wisconsin.

Welcome. We are glad you're with us.

Robert Tessier—did I get that correct—is Executive Director of the Connecticut Coalition of Taft-Hartley Health Funds. Mr. Tessier previously served as the President of the Coalition for eight years and was the administrator for the New England Health Care Employees Welfare and Pension Funds from 2000 to 2007. He served in a similar capacity for the Connecticut Carpenters Health Pension Annuity and Apprentice Training funds from 1995 to 2000. Prior to that Mr. Tessier served as the Legislative Director and Deputy Commissioner of the Connecticut Department of Labor under then Governor Lowell Weicker.

Welcome, Mr. Tessier. We are glad you're with us.

Finally, John Farrell founded J.J. Farrell Associates in 1992 and has been representing hospitals and health systems since then. Prior to founding his company, Mr. Farrell served as Commissioner of Hospitals and Health Care for two Connecticut governors. Before beginning his career in public service, Mr. Farrell was Division Director of Blue Cross Blue Shield of Connecticut and financial manager for Memorial Sloan Kettering Cancer Center. In 1995 he helped form United Risk Assessment and Management, LLC, a health care actuarial firm which merged with Urix, LLC in 2002.

Welcome, Mr. Farrell.

Before we get started, a word about the light. You will see in front of us there is a green light, yellow and red light. When you start the green light will go on. You will start your oral testimony. When the yellow light goes on you will have about a minute to summarize. When the red light goes on we will ask you to quickly summarize. In Washington we have a different system, we have a trap door underneath the witness. Because we are in more of a laid back situation, we won't do that. We would ask you to move on as quickly as you could.

The final thing, to bring focus as to Mr. Courtney's efforts that bring us here. I was struck by one statistic that comes from the Employee Benefits Research Institute which is this, a woman who goes to her physician today and is told that she has stage two cancer, which is a pretty big deal, pretty serious has a 90 percent chance of survival over five years if she has health insurance, but if that same woman goes to the doctor and is told she has stage one cancer, which is the best of all bad news, under the circumstances is what you want to hear. If she has stage one cancer, but no health insurance she has an 80 percent chance of survival

over five years. That is what this is about. If that woman is your mom or your sister or your daughter, that is what this is about.

The stark difference between what happens with and without health insurance is stunning. What we are trying to do here today is find a way so we can all agree to fix that problem. We are going to go through the whole panel then go through our questions.

STATEMENT OF NANCY DAVENPORT–ENNIS, CHIEF EXECUTIVE OFFICER, NATIONAL PATIENT ADVOCATE FOUNDATION

Ms. DAVENPORT-ENNIS. I would like to begin my testimony by saying to you I am here to speak on the behalf of the patients we have served for over 12 years. I think our patients more than 21 million of them represent the aggregate of what's being seen in America. It is practical issues such as preexisting conditions that are standing in the way of access to health care for people in America. Mr. Courtney as you have recognized we appreciate so much this legislation.

Let me share with you that in 2005 our case managers reported a very significant uptick in the number of preexisting cases. We reached out to the graduate school at Dartmouth. We commissioned a study to confirm what is done at the State and Federal level and is the issue of preexisting conditions really driving up the uninsured rolls. At the same time we looked at chronic diseases which are automatically going to disqualify a person from applying. You are going to be faced with a preexisting condition at that point. We also went to our own database to see what is the type of issue that these people with preexisting issues are facing. What we saw repeatedly, the loss of one insurance plan, inability even if they had the dollars to enroll in another health plan. Then the national mantra is go seek coverage in a State high risk pool. We spent a lot of time doing research on that. That is what I would like to focus on today.

The first myth, namely the State high-risk pools provide coverage to millions of individuals across the country. Our research shows that in total, State high-risk pools cover only about 195,000 people and are not operational in every State. We have States such as Florida that say they have a high-risk pool. In 17 years they have not been able to accept an application, approve fund coverage to get to benefits.

Myth number two, those who qualify for State high-risk pools are going to get their treatments, benefits and services covered. We actually worked with patients who sent us a copy of the letter from the State high-risk pool acknowledging they had been approved only to find out one week later in a second letter you're approved, but currently there is no funding available to fund you into this program or give you access to health care so you go back to creating a safety net program.

I think myth number three, State high-risk pool coverages are affordable. For Connecticut the average premiums in a State high-risk pool is 125 to 150 percent of the average standard market rate for private health plans anywhere in America. What does this mean? What it means for a woman 50 years of age seeking a $500 deductible policy in Minnesota, she would pay $450, Oregon $560,

Texas $737, and Illinois $865. Candidly, the patients we serve can't afford that. Over and over we see that.

The fourth myth, the State high-risk pool insurance does not ban coverage for preexisting conditions. What we know from our experience is if we are fortunate enough to get a person enrolled in a State high-risk pool, as we recently did here in Connecticut with a 45 year old patient who had the financial ability to pay COBRA until she could get in the plan here in Connecticut she was able to do that only because she had resources, but without proof of creditable coverage until the day she was enrolled, she would have been subjected to the 12-month preexisting period with no reimbursement for preexisting disease and would also be subject to the 12 month look back period.

The fifth myth, high-risk pools are well funded and open to all applicants. Regrettably, they are not. There is not a finger of guilt to be pointed to anyone. It is reality. States don't have the dollars to fund these pools. They are not able to. They may go to the Federal Government to get a grant. If they do, the maximum amount the Federal Government contributes is $1 million to these pools. From our point of view, when we look at the work we did initially around the preexisting condition, we went over to meet with our friends over at AHIP and said let's join together to try to find a solution for the issue of preexisting conditions. This was about a year ago. At that point it was not a big problem according to the folks we met with at AHIP. Now there is a proposal for them to offer different ways to handle it.

Way number one is to shift that to the States. We are insisting preexisting conditions be addressed. It's got to be addressed at the Federal level.

I thank the committee for giving me this opportunity this afternoon.

[The statement of Ms. Davenport-Ennis follows:]

Prepared Statement of Nancy Davenport-Ennis, Founder, President & CEO, Patient Advocate Foundation and National Patient Advocate Foundation

Good Afternoon. Mr. Chairman and Members of the Committee, my name is Nancy Davenport-Ennis and I am the Founder, President & CEO of Patient Advocate Foundation and National Patient Advocate Foundation. I am pleased to be here today to provide testimony in support of HR 2833, the "Preexisting Condition Exclusion Patient Protection Act of 2007".

For twelve years, Patient Advocate Foundation has provided direct patient services to patients throughout the country that have been diagnosed with a chronic, life-threatening or debilitating illness. Last year, Patient Advocate Foundation received approximately 6.8 million contacts for information or service from patients seeking assistance for access to care issues. Of those, 44,572 became full patient cases involving communications made by Patient Advocate Foundation staff on behalf of a patient in order to reach positive resolution.

In recent years, Patient Advocate Foundation professional case managers have seen pre-existing conditions become a more prominent barrier for patients to gain and/or maintain their health insurance coverage. As a result, in May 2005 NPAF commissioned a study by the Tuck Graduate School of Business at Dartmouth College on pre-existing conditions and how they contribute to the "job-lock" phenomena. I am submitting a copy of the report as part of my testimony in addition to several briefing documents NPAF has developed on state high-risk pools. The report confirmed the issues our case managers dealt with when assisting patients with preexisting conditions and provided a basic analysis of the limited role state high-risk pools play in providing health coverage to this population of patients.

The Centers for Disease Control and Prevention has estimated that 1 out of every 3 adults is living with at least one chronic condition. Since chronic conditions such

as asthma and diabetes are often considered pre-existing conditions by insurers, it is very possible that one-third of the U.S. population could face pre-existing condition exclusions and waiting periods at some time during their lives.

Through Patient Advocate Foundation's work, we know that patients with pre-existing conditions may delay care during their waiting period because they cannot pay for the care out-of-pocket. For other patients, they are denied insurance coverage altogether because they are deemed too "high-risk". For these patients, there are few options for receiving necessary care. Oftentimes, these individuals are referred to their state's high-risk pool.

NPAF commissioned some background work on these high-risk pools, and we are very concerned about high-risk pools being used as the blanket solution to providing access to health insurance for patients with pre-existing conditions who are locked out of the insurance market. What we found is there are many myths about state high-risk pools:

Myth No. 1. State high-risk pools provide coverage to millions of individuals across the country. The reality is that in total, state high-risk pools cover only about 190,000 individuals and are not operational in every state. Only 34 states have high-risk pools and with a total uninsured population around 47 million, high-risk pools are barely impacting the number of uninsured. That's less than ½ of 1% of the uninsured are able to access high-risk pools (Kaiser Family Foundation, December 2006).

Myth No. 2. Those who qualify for a high-risk pool can get their treatments, benefits, and services covered. Again, the reality is that some high-risk pools have long waiting lists and admittance is not guaranteed. Many states are unable to accept every eligible individual because of funding constraints.

Myth No. 3. State high-risk pools coverage is affordable. The reality is that average premiums in a state high-risk pool are 125 to 150 percent of the average, standard market rate for private health insurance. Due to the fact that these premiums are actually higher than the average, standard market rate, individuals who were unable to obtain prior health insurance due to cost restrictions are still unable to obtain coverage through a state high-risk pool (The Commonwealth Fund).

Myth No. 4. High-risk pool insurance doesn't ban coverage for pre-existing conditions. In fact, most state high-risk pools have look-back and waiting periods for coverage. Most high-risk pools exclude coverage for a pre-set period of time, based on a pre-existing condition, for an average of six months. Waiting periods are implemented to prevent individuals from applying for coverage once they have a condition and then releasing the coverage once the condition has been remedied (The Commonwealth Fund & Kaiser Family Foundation).

Myth No. 5. High-risk pools are well funded and open to all applicants. The truth is that high-risk pools are under-funded in most states. A majority of pools are funded through assessments placed on insurers, premiums collected by individuals enrolled in these pools, and general state revenues. Very little funding for state high-risk pools comes from the federal government. The State High Risk Pool Funding Extension Act of 2006 provided seed grants to states that wished to implement a high-risk pool. These grants were set at a maximum of one million dollars, not nearly enough to provide comprehensive health care coverage to the population of individuals with pre-existing conditions who need access to health insurance. New applicants are not always accepted in high-risk pools either. An example is that in 1991, Florida stopped accepting new applicants to its high-risk pool. Although it has been over 17 years since Florida's high-risk pool accepted new members, Florida is considered to have a high-risk pool (The Commonwealth Fund).

The state of Connecticut created a high-risk pool in 1976 to help individuals who are unable to acquire health insurance due to pre-existing conditions. As of December 31, 2006, 2,523 individuals were enrolled and the average premium paid by the patient (not including state contribution) for a 50 year old male was approximately $717 a month. The Connecticut Health Reinsurance Association, as the risk pool is referred, implements a 12 month pre-existing condition waiting period and is governed by a 6 month look-back period for pre-existing condition. Both of which are consistent with the HIPAA statute. In addition, the Connecticut high-risk pool imposes a lifetime maximum of $1 million for enrollees which could effectively leave a patient without any option for health coverage once that limit is reached (Kaiser Family Foundation).

The Connecticut risk pool has worked for some patients like the 45 year old woman diagnosed with breast cancer three and a half years ago that contacted Patient Advocate Foundation. The woman had been prescribed oral adjuvant therapy for a period of five years and had continued her COBRA coverage but it was about to terminate when she contacted Patient Advocate Foundation. She had previously attempted to obtain coverage through private insurance but as a result of her cancer

diagnosis, which was considered a pre-existing condition, an exclusionary rider would have been placed on her health coverage plan; this rider would have left her virtually uninsured for her cancer treatment and related care services. Fortunately, the Patient Advocate Foundation case manager assigned to her was able to assist the patient in applying for coverage through the risk pool through which she later obtained coverage. Since this patient was very well informed, and had adequate financial resources, she was able to continue her COBRA coverage in order to maintain creditable coverage so that she wouldn't be subject to a pre-existing condition waiting period. I commend the state of Connecticut for its dedication to providing individuals with pre-existing conditions coverage through a high-risk pool; however, as I'm sure you are aware, there are many other Connecticut residents that find themselves unable to access health coverage through the risk pool for a variety of reasons, one being the high cost of coverage.

We have also found that the application and enrollment process for high-risk pools is also fraught with many barriers. In most states, individuals applying to high-risk pools must provide proof of rejection from health insurance coverage, proof that an individual is presently insured with a rider attached or has health insurance that is rated, proof that an individual is presently insured with a higher premium, or proof that an individual is eligible for the portability option under HIPAA. Such enrollment requirements are particularly burdensome for patients struggling with chronic and life-threatening illnesses that should be focusing their attention on their treatments and recoveries.

In December 2007, America's Health Insurance Plans, the trade association for many of the country's largest health insurers, recommended that states should create Guarantee Access Plans to provide coverage for uninsured individuals with the highest expected medical costs. In return, health plans would limit rescission actions and grant coverage to a certain percentage of applicants not eligible for the Guarantee Access Plan. NPAF applauds this acknowledgment that there are currently serious barriers in the individual market particularly for patients with pre-existing conditions. While their proposal appears to be a step forward in the effort to prevent denial of benefits based on health status, NPAF is concerned that the plan places too much responsibility on states, who are already burdened with expanding uninsured populations and funding obstacles associated with operating high-risk pools.

In closing, while there are some patients who are benefiting from state high-risk pools, generally these risk pools are under-funded, have long wait lists, and exclude coverage of pre-existing conditions for a set amount of time. We strongly believe that reform at the federal level is necessary for individuals with pre-existing conditions so that they are able to access health insurance coverage in a timely manner.

Chairman ANDREWS. Thank you for your testimony and personal experience. That is motivating. Thank you for your efforts.

Ms. Gould, welcome to the committee.

STATEMENT OF RITA GOULD, RETIRED PROFESSOR

Ms. GOULD. I feel strongly about H.R. Bill 2833, that it pass. I want to thank Congressman Courtney for going to this length to see it does pass. I am here to support it 100 percent.

My situation is probably very similar to a lot of people. For example, I contacted AARP when I was in need of solo insurance for a six-month period. And I completed a very detailed application. And I was very honest. And a month later I was told I was rejected because I had Type II diabetes and my medication was too costly. My question was to them why did you bother to have me fill out the application when you knew I was going to be rejected. I looked into other solo insurance plans and found they didn't exist or they had similar stipulations. I also have a friend who sells health insurance and she couldn't find any company to insure me. She also confirmed that insurance companies reject many people with less complicated medical issues than diabetes.

My only option was going without insurance or being in a pool of high-risk "Uninsurables" through the Connecticut Reinsurance

Program. I chose the latter. However, this was extremely costly. It was $1242.21 per month, more than my mortgage and more than twice what I had been paying monthly on COBRA which was already a financial stain. In addition to the premium I had $30 office visit co-pays and prescription co-pays. Last year I paid almost $11,000 out-of-pocket in premiums and medication costs. I am not poor. I worked all my life and I do think that I was certainly discriminated against and people like me were discriminated against. Type II diabetes, also called non-insulin dependent diabetes, is the more common form affecting 90 percent to 95 percent of the 21 million people with diabetes.

And we are not all fat couch potatoes. I have been affected by this disease for 15 years. Again, I never missed work because of it, nor have I been hospitalized. I am a very productive member of society, doing volunteer work and I am still working at Central Connecticut State University in the teacher education program.

Believe it or not, I am not a fan of universal health care. But I do believe much can be done now to help people in such similar situations. This bill will not help me, but I feel very strongly about it. In fact, I should be home making ravioli for Easter, but I am here because I truly believe that Mr. Courtney's bill must be passed.

I could go on and on, but I think I am just going to stop here and give everybody else a chance.

I think I said what I need to say. There are a lot of people in situations in this State that need your help and again I agree with my colleague here, it needs to be on the Federal level. And I will do whatever I can to help get this bill passed. Thank you.

[The statement of Ms. Gould follows:]

Prepared Statement of Rita D. Gould, Retired Professor

I contacted newly elected Congressman, Joseph Courtney in February 2007 after being refused solo medical insurance for a six-month period (March 1, 1007—September 1, 2007). Up until that time, I was covered under COBRA for the maximum time allowed on my husband's United Technology Corp. insurance. I was allowed to remain on his insurance for five years after his retirement at 65 and then on COBRA. However, there were no company options to cover me for that six-month period until I turned 65.

I contacted AARP and completed a very lengthy, detailed application for their solo plan. After a month, I received a letter telling me that my application was refused because I had Type II diabetes and that my medication was too costly. Panicked, I looked into other health plans and found that solo plans either didn't exist or had similar pre-existing stipulations. I have a friend who sells health insurance, but she could not find any company to insure me. She confirmed that insurance companies reject many people with less complicated medical issues than diabetes.

My only option was going without insurance or being placed in a pool of "Uninsurables" through the Connecticut Reinsurance Program. I chose the latter; even though the monthly cost of this insurance was $1242.21 per month—more than my mortgage and more than twice what I had been paying monthly on COBRA, which was already a financial strain. In addition to the premium, I had $30 office visit co-pays and prescription co-pays. At this time, my husband was retired and I was an adjunct professor in the teacher education department at Central Connecticut State University. Could I afford this? Not really. Was I angry? To say the least. I appreciated Congressman Courtney's office staff, namely Dorothy Grady, listening to my plea and subsequently organizing a neighborhood meeting at my home with the congressman and some neighbors to discuss healthcare concerns.

Type II diabetes, also called non-insulin dependent diabetes, is the most common form of diabetes, affecting 90%–95% of the 21 million people with diabetes—and we are not all fat couch potatoes. I have been affected by this disease for 15 years and have never missed work because of it nor have I been hospitalized. However, that

didn't matter to AARP. In 2007, the cost of my insurance premiums and prescription drugs was $10,872! By the way, when it came time for me to select a Medicare supplement, AARP and others wouldn't stop soliciting me. My diabetes hadn't disappeared.

In all 45 years of my professional working life, I have willingly paid my fair share toward caring for the less fortunate, believing that it is my moral and Christian obligation to do so. But being denied insurance because of having a bad gene, made it quite evident that welfare recipients aren't the only ones discriminated against. The government is not doing enough to extend medical coverage to hard-working citizens like me at a reasonable cost or from preventing people from going bankrupt because of an uninsurable pre-existing condition.

As an educator, I have witnessed what the Department of Education did to dilute the American educational system, so it is not surprising that I am NOT a proponent of universal healthcare and believe that if medical care is expensive now, wait until it is "free." However, I applaud Congressman Joe Courtney for tackling the difficult subject of insurance companies' right to deny coverage to consumers regarding pre-existing medical conditions. He is enthusiastic and sincere about helping his constituents in what can constitute a fight for their lives, and I sincerely hope that his bill is passed.

While passage of this bill will help many people, in order to make a real difference in healthcare, you need to address the Employee Retirement Income Security Act of 1974—ERISA—in its entirety. This act allows insurance companies to do basically whatever they wish. Perhaps the standards for these voluntarily established health plans in private industry should be more stringent in order to protect employees. The COBRA amendment was necessary, but when people lose their jobs, they usually don't have enough money to pay the COBRA premiums. Further, HIPPA is a noble effort but it isn't working. If the idea of HIPPA is privacy, why am continually inundated with diabetes newsletters and information about purchasing diabetic supplies from sources I've never contacted? Let's face it; once your name is in a computer, anyone in the world can access it easily. And when will there ever be parity for mental health coverage? Discrimination is alive and well in healthcare.

Even as a diabetic, I am still a productive member of society. As much as I believe Medicare might like it, I am not dead yet, nor am I here to make Congress's job easy. I should be home today making ravioli and Easter bread, but I believe wholeheartedly that Congressman Courtney's bill must be passed and will do whatever I can to see that it does. This bill won't help me, but it may help at least 21 million others. I truly believe that it is high time the inequities and discrimination within the medical coverage system cease. If Congressman Charlie Wilson single-handedly can wage a war with the Mujahideen against the USSR, just think what 100 congressional representatives working together for the welfare of Americans' health can do. I sincerely hope they are up for the challenge?

Chairman ANDREWS. Ms. Gould, thank you. We wish you'd brought some of the ravioli with you. We regret keeping you away from your kitchen. Thank you for sharing your story.

Mr. Stirling, welcome to the committee.

STATEMENT OF JAMES STIRLING, CHIEF EXECUTIVE OFFICER, STIRLING BENEFITS

Mr. STIRLING. Thank you, Mr. Courtney, for setting this up. And, Congressman Andrews and your staff, thanks for making sure we got here. I appreciate you coming to Connecticut instead of having this in Washington.

For the record, my name is James Stirling. I am delighted to be able to testify on H.R. 2833.

When HIPAA required group health plans to modify their pre-existing condition periods in 1996, many groups dropped their limits altogether. They did this because number one, groups do not like denying coverage to those employees who need it. Number two, HIPAA made the cost of administering their credible coverage statements not worth the claim savings.

HIPAA gutted the preexisting condition provision except for these five or six million people. I think H.R. 2833 will continue that trend in the group market, but it may have some unintended problems with the individual market.

H.R. 2833 treats all plans equally, regardless of if the plan is self-funded, fully insured, or collectively bargained. This keeps the playing field level. With a 30-day look back, three-month limitation many more group plans will drop their pre-ex entirely. Employees will be able to move more fluidly from one employer to another, thus reducing "Job Lock" and will have positive consequences even if it does cost the plan some more money. Indeed, those costs will be passed on to the sponsor who will pass them on to their employees either by lower wages, higher contributions, or they will be forced to raise the prices for their goods and services.

So the question for the group market really is, how much will such a bill cost employees and consumers ultimately? So long as all plans are treated the same, I come to conclude the answer is not too much. In 1986 some thought that COBRA was so onerous it would end employer-sponsored coverage. It did not whatsoever. The same with HIPAA. But the group market adapted. The individual market will also adapt.

But there are some more significant unintended financial consequences. Individual plans are inherently prone to adverse selection. To make a profit, maybe that is the key point here. Selection carriers utilize several tools to make a profit. They can limit coverage for preexisting conditions, reduce benefit levels, increase rates for new policies, or increase premiums at renewal.

H.R. 2833 dulls one of these tools. And to continue profits, carriers will have to sharpen the others. I am afraid that may have a sting all of its own. This does not mean this approach should be abandoned, but we should be cognizant of this potential consequence and the rates will likely increase to cover the preexisting conditions of a minority of policyholders. That said, the individual market reforms must continue.

I believe we are at the point where defined benefit pension plans were 20 years ago. Then employers defined what pension benefits employees received, just like employers now define what health benefits their employees receive today. Now 20 years later, the employee controls the investments in their portable 401(k)s. With some reforms, a parallel shift may be under way with our nation's health programs.

To your point Chairman Andrews, entire peoples coming in higher access, low cost plans across the board, similar to how Social Security provides a base for retirement savings, Federal and State governments could provide health care with employer and individual plans building on that base.

For this option to develop we will need to make the individual market function more like the group market. And H.R. 2833 moves us in that direction. But we will need to go further than your bill shows. Perhaps, with some combination of community rating, broad based pooling and carrying health credits forward from one plan to another similar to the way you carried forward credits from a previous plan.

At its heart, H.R. 2833 is an insurance reform bill. I must conclude no amount of insurance reform will by itself be able to make the cost of our health care system sustainable. Until we find ways to pay for health instead of paying for healthcare, we will only be tweaking at the edges.

H.R. 2833 will increase parity for all types of plans and that is a good step.

Thank you for opportunity to share my views. And thank you for furthering the work in this area.

[The statement of Mr. Stirling follows:]

Prepared Statement of James Stirling, Chief Executive Officer, Stirling Benefits

For the record my name is James Stirling. I am CEO of Stirling Benefits, Inc. a Third Party Administrator (TPA) of group health plans located in Milford CT and Chairman of the Board of the Society of Professional Benefit Administrators (SPBA) in Washington, D.C. Thank you for this opportunity to testify on HR 2833.

When HIPAA required group plans to modify their pre-existing condition periods in 1996, many groups dropped their limits altogether. They did this for two reasons: 1) groups do not like denying coverage to employees that need it, and 2) the cost of administering the credible coverage statements was not worth the claim savings compared to their pre-HIPAA plan provisions. This bill will further this trend in the group market, but may have unintended consequences in the individual market.

HR 2833 treats all plans equally, regardless if the plan is self funded, fully insured or collectively bargained. That keeps the playing field level. The result will likely be that many group plans will drop their pre-ex clauses entirely, continuing the trend started with HIPAA portability provisions in 1996. Employees will be able to move more fluidly from one employer to another. This reduction in "Job Lock" will have positive consequences for our dynamic economy, even if it does increase costs for plans.

There will be added costs. Insurance carriers or administrators will shift the added cost to the plan sponsors. Employers will pass these on to their employees via lower wages or higher contributions, or increase the cost of their goods and services to pay for the increase.

So the question for the group market is: how much will such a bill cost employers and ultimately consumers? I think the answer is not too much. In 1986, some thought that COBRA was so onerous that it would end employer-sponsored coverage. It did not. We heard the same predictions with HIPAA portability a decade later, but group coverage continues. In the group market, this bill will have a minimal overall cost impact.

The individual market will also adapt, but there may be more significant unintended consequences. Individual plans are inherently prone to adverse selection. To offset that selection carriers utilize several tools to make a profit. They can limit coverage for pre-existing conditions, reduce benefit levels, increase rates for new policies, or increase premiums at renewal. By dulling one of these "tools," they will have to sharpen the others. The remaining tools may have a sting of their own. This does not mean this approach should be abandoned, but we should be cognizant of this potential consequence and seek to combine the pre-ex modifications with other needed reforms.

I'm in favor of reforming the individual market. I believe that we are at the point where defined benefit pension plans were 20 years ago. Then, employers defined what pension benefits employees received, just like they define health benefits today. Now, the employee controls the investments in their portable 401(k)'s. With some reforms, a parallel shift may be under way with our nations health programs. Similar to how Social Security provides a base for retirement savings, the government, could provide basic health coverage to all legal residents, with employer and individual plans building on that base.

For this option to develop we will need to reform individual market to create a viable, alternative to employer-sponsored coverage. Steps that make the individual market function more like the group market, as this bill does, are in the right direction. But we will need to go further, perhaps with some combination of community rating, broad based pooling, and carrying health credits forward from one plan to another.

At its heart, this is an "insurance" reform bill. I must conclude that "insurance" reform, by itself, will not do enough to make the cost of our health care system sus-

tainable. Until we find ways to pay for "health" instead of paying for "healthcare," we will only be tweaking at the edges. H.R 2833 will increase parity for all types of plans, and that's a good step. To help those with ongoing health conditions, over the long term, we will need a more significant overhaul, not just of insurance laws, but the way care is delivered. We must find ways to align all our interests to pay for health, not just healthcare.

Thank you for the opportunity to share my views, and thank you also for all that you do to serve the public good.

Chairman ANDREWS. Thank you for your thoughtful contribution. Ms. Horoschak, glad you're with us.

STATEMENT OF DONNA HOROSCHAK, VICE PRESIDENT OF PRODUCT POLICY, AMERICA'S HEALTH INSURANCE PLANS

Ms. HOROSCHAK. Thank you. I am Donna Horoschak with America's Health Insurance Plans.

A little about our organization. Our members offer a broad range of health products both in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify today and we commend the subcommittee for holding this meeting examining the implications of these issues both for consumers and for the health insurance marketplace.

Our written testimony focuses on proposals AHIP has endorsed for expanding coverage to all Americans, our members, including that directly address the circumstances of uninsured persons who have preexisting medical conditions. Our written testimony also discusses the survey findings on the individual health insurance market, a survey that we conducted as well as research findings on the unintended consequences of a NPAF and in the absence of universal coverage.

I would like to focus my testimony today on our proposals which are designed to insure no one falls through the cracks of the health care system while recognizing both the private and public sector and public programs have a role in meeting this challenge.

In two, our proposal includes a comprehensive set of targeted policy proposals that would expand eligibility for public programs and enable all consumers to purchase health insurance with pretax dollars, provide financial assistance to help working families afford coverage and encourage States to develop and implement access proposals.

More recently we announced a proposal for reforming the individual health insurance market through a new strategy that calls for shared responsibility between the public and private sectors. This three-part initiative includes first a strategy that States can implement now to guarantee access to health insurance coverage to all Americans and seek coverage in the individual market, including those preexisting medical conditions. Under our approach, we are urging States to establish Guarantee Access Plans to provide coverage for individuals who are not eligible for other coverage and have the highest medical costs, that is costs that exceed 200 percent of the average claim cost. If an individual is not eligible for coverage under those provisions through Guarantee Access Plan, then they would be eligible for a guarantee issue policy in the pri-

vate sector market that would be a premium capped at 150 percent of the standard rate.

Further when a Guarantee Access Plan is first established, a one-time open enrollment period should be held for uninsured individuals where they would be able to enroll in the program without application of any preexisting condition exclusion.

Our proposal also encourages States to create a sliding-scale premium subsidy program with additional financial assistance for those with the highest health care costs and to fund Guarantee Access Plans from a broad base of sources to ensure that coverage remains affordable for those who are currently insured.

Second, our members support a series of operational reforms to give consumers peace of mind when purchasing individual health care coverage and this includes limiting the use of the preexisting condition exclusions, restricting rescission actions and establishing a new third-party review process for preexisting rescission conditions and rescission decisions.

For example, we are recommending that if an applicant for an individual health insurance policy makes a complete and accurate disclosure of a preexisting medical condition and then a policy is issued to that individual, then the insurer cannot later apply a preexisting conditions exclusion to that condition at a later date that was disclosed in the application. In addition, to make sure the applicants make appropriate disclosures, we would support a proposal that would require health insurance plans to make sure that applications are clear and understandable.

Furthermore, to make the process transparent, we would also support an independent third-party review anytime a claim is denied because of a preexisting conditions exclusion. Some could concentrate into the group insurance market. We have discussed this. We anticipate they will also consider looking at this in the group insurance market as well as the individual insurance market. That when they do that they will consider the impact these changes could have in both of those markets.

Third, our proposal also outlines five critical steps that States would need to follow if they seek to achieve universal participation by requiring their citizens to have coverage. If the State takes these steps and achieves universal participation, then health insurance plans could then guarantee coverage to all applicants without regard to preexisting medical conditions.

Thank you again for this opportunity to testify. Americans Health Insurance Plans and members stand ready to work with us to develop solutions for extending health insurance coverage to all Americans.

[The statement of Ms. Horoschak follows:]

Prepared Statement of Donna Horoschak, Vice President, Product Policy, America's Health Insurance Plans

Mr. Chairman and members of the subcommittee, I am Donna Horoschak, Vice President of Product Policy for America's Health Insurance Plans (AHIP), which is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. AHIP's members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify on the needs of individuals who seek health insurance coverage following the onset of medical problems. We commend the

subcommittee for examining the implications of these issues both for consumers and for the health insurance marketplace.

Our testimony today will focus on proposals AHIP has endorsed for expanding coverage to all Americans, including solutions that directly address the circumstances of uninsured persons who have preexisting medical conditions. Our proposals are designed to ensure that no one falls through the cracks of the U.S. health care system, while recognizing that both the private sector and public programs have a role to play in meeting this challenge. For tens of millions of Americans, the need to repair the health care safety net is a deeply personal issue requiring bold solutions that can be implemented in a timely fashion. We are committed to working with members of Congress to advance meaningful reforms that provide affordable coverage options for all Americans.

Other issues we address in our testimony include survey findings about the current state of the individual health insurance market and research findings on the unintended consequences of enacting certain health insurance reforms in the absence of universal coverage. These findings provide important insights into the strengths of the current system and lessons learned from state reform initiatives over the past 15 years.

Solutions for the Uninsured and Those With Preexisting Conditions

AHIP and our members have outlined a number of promising solutions for addressing the needs of individuals with preexisting medical conditions and high health care costs, while also confronting the broader issue of the uninsured.

In November 2006, AHIP announced a proposal for expanding access to health insurance coverage for all Americans. Our proposal includes a comprehensive set of targeted policy proposals that would expand eligibility for public programs, enable all consumers to purchase health insurance with pre-tax dollars, provide financial assistance to help working families afford coverage, and encourage states to develop and implement access proposals.

More recently, in December 2007, AHIP announced a proposal for reforming the individual health insurance market through a new strategy that calls for shared responsibility between the public and private sectors. This three-part initiative includes a plan to guarantee access to health care coverage to all Americans, new initiatives to give consumers peace of mind about individual health care coverage, and steps for states to take if they are considering a requirement for universal participation.

State Guarantee Access Plans

First, AHIP is proposing a strategy that states can implement now to guarantee access to health insurance to all who seek coverage in the individual market, including those with preexisting medical conditions. Under this plan, we are urging states to establish Guarantee Access Plans to provide coverage for uninsured individuals with the highest expected medical costs. If an individual is not eligible for coverage through the Guarantee Access Plan, health plans would then provide coverage to that individual on a guarantee issue basis with premiums capped at 150 percent of the standard rate.

We are recommending that when a Guarantee Access Plan is first established, a one-time open enrollment should be held for uninsured individuals to obtain coverage with no preexisting condition exclusions. Our proposal also would make coverage available in the Guarantee Access Plan without preexisting condition exclusions for individuals who maintain continuous coverage. We further recommend that Guarantee Access Plans should be available to individuals who are not eligible for employer-sponsored health coverage, a government program, or other coverage and, additionally, whose claims costs are expected to be 200 percent or more of the statewide average.

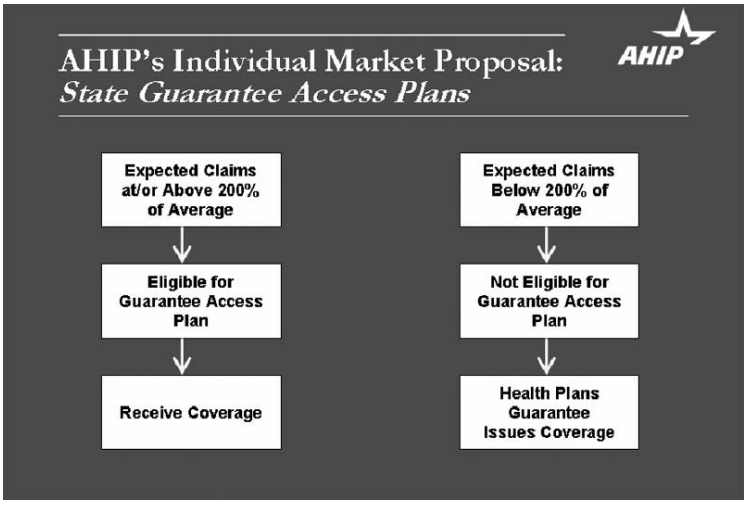
Guarantee Access Plans would offer a range of coverage options with varying premiums, resulting from different levels of cost-sharing. Premiums would be equivalent to 150 percent of standard market rates, and coverage options would reflect benefit packages available in the private market.

Under AHIP's proposal, if an individual is declined coverage by the Guarantee Access Plan, all health insurance plans would guarantee coverage until each plan's total individual enrollment reaches a predetermined level (e.g., 0.5 percent of enrollment). When all health insurance plans have reached the predetermined level, the level would be raised and all plans would again guarantee coverage until they meet the new level.

Health insurance plans also would provide assistance with the enrollment process for the Guarantee Access Plan. This includes informing individuals about the avail-

ability of coverage under the Guarantee Access Plan and, at their request, transferring information to the Guarantee Access Plan application.

Finally, to keep coverage as affordable as possible, our proposal calls on states to allow health insurance plans to offer features such as pharmacy programs that promote both value and safety; disease management, preventive, and care coordination programs that bring evidence-based care into everyday practice; and new benefit design and payment incentives that reward quality and value. We also encourage states to create a sliding-scale premium subsidy program with additional assistance for those with high health care costs and, additionally, to fund the Guarantee Access Plans from a broad base of sources to ensure that coverage remains affordable for those who are currently insured.



Operational Initiatives by Health Insurance Plans

Second, AHIP's proposal includes a series of operational reforms to give consumers peace of mind when purchasing individual health care coverage. This includes limiting the use of preexisting condition exclusions, restricting rescission actions, and establishing a new third-party review process for preexisting conditions and rescission decisions.

Specifically, our proposal recommends that if an applicant for individual health insurance makes a complete and accurate disclosure of a preexisting condition and is issued a policy, health insurance plans should not apply a preexisting conditions exclusion to that condition at a later date. In addition, to make sure that applicants make appropriate disclosures, our proposal emphasizes that health insurance plans have a responsibility to make applications clear and understandable.

Furthermore, to increase transparency in how preexisting conditions exclusions are applied, our proposal for reforming the individual health insurance market also calls for a new third-party review process, established by state legislation, to allow consumers to challenge claim denials based on a preexisting conditions exclusion. This process should include timeframes for reaching a decision, with expedited review available for emergency situations, and the participation of at least one medical professional and one attorney on the independent review panel.

Our initiatives have been developed with the goal of enhancing peace of mind for consumers who purchase coverage in the individual health insurance market and for consumers who have had a claim denied under a preexisting conditions exclusion in their policies. Unlike pending proposals that would make piecemeal changes to the parameters for preexisting condition exclusions, these steps provide a strong foundation upon which Congress can enact more comprehensive reforms.

Constructing an Individual Mandate for Coverage

Third, AHIP's proposal outlines five critical steps that states would need to follow if they seek to achieve universal participation by requiring that every citizen in the state have health care coverage. If a state takes these steps and achieves universal participation, health insurance plans could then guarantee coverage to all applicants, without regard to preexisting medical conditions.

While AHIP is not advocating an individual mandate, we have explored this issue and have identified five critical steps that states should take as part of any strategy for achieving universal participation:

- develop an insurance coverage verification system;
- enforce the requirement to purchase and maintain coverage;
- establish an automatic enrollment process and be prepared to provide backstop funding if individuals do not fulfill their responsibility to purchase coverage;
- create a premium subsidy program for moderate- and low-income individuals and families, while also providing additional assistance for those with high health care costs; and
- fund coverage initiatives from a broad base of sources.

The establishment of a universal participation program, based on these steps, could avoid the unintended consequences that have hampered many well-intentioned efforts by states to assist those pursuing coverage in the individual health insurance market.

Collectively, these proposals reflect our members' strong commitment to ensuring that no American falls between the cracks of public and private programs and that individuals can have their disputes reviewed by an objective third party.

Survey Findings on Individual Health Insurance Market

In December 2007, AHIP released a new survey of the individual health insurance market. The findings of this comprehensive survey indicate that individually purchased health insurance is more affordable and accessible than may be widely known and that it offers a broad array of benefits.

According to the survey, 89 percent of applicants who went through the application process were offered coverage in the individual market. Forty percent of these offers were at standard premium rates and 49 percent were offered at lower (preferred) rates. Even among those in the 60-64 age category, 71 percent were offered coverage and 74 percent of these were at standard or preferred rates.

Nationwide, annual premiums averaged $2,613 for single coverage and $5,799 for family plans in the 2006-2007 period. As shown in the table on the following page, premiums varied by state, reflecting a variety of factors, including premium rating and underwriting rules, differences in health care costs, demographics, and consumer benefit preferences. Premiums were significantly higher in states with "guaranteed issue" and "community rating" requirements that place restrictions on premium variation and underwriting. However, approximately 95 percent of the policies surveyed were sold in states where the average annual premium was under $3,400 for single coverage or $7,200 for family coverage.

INDIVIDUAL MARKET, AVERAGE ANNUAL PREMIUMS BY STATE

[Single Coverage, 2006–2007]

State	Average Annual Premium
MASSACHUSETTS	$8,537
NEW JERSEY	$5,326
NEW YORK	$4,734
RHODE ISLAND	$4,412
PENNSYLVANIA	$3,949
MAINE	$3,686
LOUISIANA	$3,377
NEW HAMPSHIRE	$3,368
NEW MEXICO	$3,362
CONNECTICUT	$3,326
NEVADA	$3,118
NORTH CAROLINA	$3,080
SOUTH CAROLINA	$2,981
FLORIDA	$2,949
SOUTH DAKOTA	$2,914
MONTANA	$2,866
TEXAS	$2,782
WYOMING	$2,688
NATIONAL	$2,613
ARIZONA	$2,591
CALIFORNIA	$2,565
WEST VIRGINIA	$2,540
COLORADO	$2,537
KENTUCKY	$2,537

INDIVIDUAL MARKET, AVERAGE ANNUAL PREMIUMS BY STATE—Continued

[Single Coverage, 2006–2007]

State	Average Annual Premium
MISSOURI	$2,518
NEBRASKA	$2,505
INDIANA	$2,504
ILLINOIS	$2,499
OHIO	$2,498
MISSISSIPPI	$2,489
OKLAHOMA	$2,435
MINNESOTA	$2,424
GEORGIA	$2,419
KANSAS	$2,363
VIRGINIA	$2,359
DELAWARE	$2,346
NORTH DAKOTA	$2,316
TENNESSEE	$2,221
MARYLAND	$2,208
ALABAMA	$2,208
IOWA	$2,202
ARKANSAS	$2,153
WASHINGTON	$2,015
IDAHO	$2,006
MICHIGAN	$1,878
UTAH	$1,574
OREGON	$1,297
WISCONSIN	$1,254

Source: America's Health Insurance Plans.

NOTE.—Results from Alaska and the District of Columbia, where the responding companies reported fewer than 500 policies in force, are included in the national totals but are not reported separately.

AHIP's survey also demonstrates that consumers in the individual market were offered a wide range of benefits, including mental or behavioral health, prescription drugs, preventive, and maternity benefits. Some level of behavioral health coverage was included in nine out of ten policies purchased. Coverage for complementary and alternative therapy was also quite popular, while vision and dental coverage were chosen much less frequently.

INDIVIDUAL MARKET, SPECIFIC BENEFITS PURCHASED, 2006–2007

[PPO/POS and HSA/MSA]

Coverage Included in Policies Purchased	Percent of Policies in Survey			
	PPO/POS		HSA/MSA	
	Single	Family	Single	Family
Adult Physicals	66.2%	67.1%	73.2%	74.8%
Allergy	71.9%	73.7%	84.5%	90.4%
Annual Ob/Gyn Visit	95.8%	94.1%	87.0%	82.1%
Bariatric Surgery	35.8%	35.0%	23.0%	15.9%
Cancer Screenings	94.1%	93.9%	90.0%	81.4%
Complementary & Alternative Therapy (Chiropractic, Naturopathy, Acupuncture, etc.)	70.0%	71.1%	75.3%	61.3%
Complications of Pregnancy	100.0%	100.0%	100.0%	100.0%
Dental	14.0%	8.5%	6.2%	4.0%
Fertility treatment	26.7%	26.7%	5.1%	3.2%
Inpatient Behavioral Health	93.8%	79.1%	89.5%	89.4%
Outpatient Behavioral Health	94.3%	84.3%	86.8%	83.3%
Normal Delivery	57.7%	59.5%	51.6%	40.3%
Oral Contraceptives	78.8%	76.6%	53.5%	46.8%
Inpatient Substance Abuse	85.0%	80.2%	86.2%	87.4%
Outpatient Substance Abuse	84.1%	78.5%	82.5%	80.8%
Vision	7.6%	17.8%	7.0%	4.2%
Well-Baby Care	88.0%	86.8%	80.2%	74.0%
Well-child visits	89.7%	88.5%	85.8%	79.4%

Source: America's Health Insurance Plans.

Research Findings on Previous State Initiatives Yielding Unintended Consequences

Last year, AHIP commissioned research that yielded important lessons about the unintended consequences that can result when certain health insurance reforms are enacted in the absence of universal coverage. In September 2007, we released a report by Milliman Inc. that examined eight states—Kentucky, Maine, Massachusetts, New Hampshire, New Jersey, New York, Vermont, and Washington—that enacted various forms of "community rating" and "guarantee issue" laws in the 1990s.

The Milliman report found that these initiatives, when enacted without universal coverage, can drive up health care costs for consumers, limit access to coverage, and have unintended consequences for healthy persons. The report also found no significant decrease in the uninsured population in states that implemented these initiatives. As a result, several states that initially implemented community rating and guarantee issue laws have since repealed or modified their laws with the intent of stabilizing the insurance marketplace and providing consumers more choice and access to coverage.

The experience of New Jersey is particularly noteworthy. In the early 1990s, the state legislature enacted a package of reforms that included community rating, guaranteed issue, and standardized plan requirements. Initially, these reforms briefly increased the number of carriers participating in the individual market and the number of persons buying individual coverage. Over time, however, these reforms led to dramatic rate increases for the standardized plans. By 2007, the number of carriers participating in the state's individual market had declined to only seven and the number of persons buying coverage in the individual market had dropped to approximately 80,000 annually—significantly below the 220,000 persons who purchased individual health insurance coverage in New Jersey in 1995.

These and other findings of the Milliman report are well worth considering in any congressional debate about preexisting conditions. The clear lesson for policymakers is that any reforms that give healthy people incentives to delay purchasing coverage will lead to unintended consequences for the broader population and diminish access to high quality, affordable health insurance. Instead of pursuing piecemeal reforms that have been tried before by states and create the unintended consequence of exacerbating existing problems, Congress should consider the challenge of ensuring that individuals with high health care costs receive coverage as part of broader policy changes that would bring meaningful relief to health care consumers.

Conclusion

Thank you again for this opportunity to testify. AHIP and our members stand ready to work with you to advance solutions for providing health insurance to uninsured persons with preexisting medical conditions. We also look forward to participating in a serious debate on the broader challenge of extending coverage to all Americans to ensure that no one falls through the cracks.

Chairman ANDREWS. Thank you very much for your views and positive ideas.

Mr. Tessier, welcome to the subcommittee.

STATEMENT OF ROBERT TESSIER, EXECUTIVE DIRECTOR, CONNECTICUT COALITION OF THE TAFT-HARTLEY HEALTH FUND

Mr. TESSIER. Good afternoon. Thank you, Representative Courtney, it's good to see you again.

Our coalition is a coalition of 17 jointly-sponsored labor management sponsored health funds. We are, taken together in the State of Connecticut, the second largest private payer of health care. Our member funds spend about $100 million on health care services every year. I can't so much speak to the problem. You, the committee, you, Representative Courtney have identified the problem. I can speak to what our experience is and tell you that for health funds that may be slightly different. Maybe different in some ways from the commercial insurers. We have a mix of funds that have preexisting condition exclusions that are applied. Funds that don't have them, never had them. Some funds, as James testified earlier,

had such exclusions, but have since dropped them. Essentially what I'm here to testify today is that this has not been a significant cost for our funds.

I have spoken to the administrators for all the large funds and several of the small funds. We are all funds that are very cost conscious. As you know, health care costs have continued to rise dramatically. Our funds get their funding through the collective bargaining process; the cost of health care has been the most controversial and difficult subject in collective bargaining for many years. We don't have extra money sitting around that we can waste. We have exhausted the areas where we can find savings. This has not been an area where funds have been able to say no, we need this. There is a significant problem here we need to be able to deny coverage. Our funds are not in the business of denying coverage in the first place. After discussion with those funds, I'm here to testify it's not as significant—on occasion it is a problem, but not something there is a great deal of savings for us.

Are we different than commercial insurers? Yes. In some ways we are different in that access to our membership, for instance, with the building trades funds typically come after people serve in apprenticeship programs or through it; they have a longer relationship with both the union employer and the fund. So we don't have a problem—I have not seen a problem with employees that have a heart attack then look for work as a carpenter or operating engineer or something. It doesn't work that way.

Also when they become eligible for coverage there is not the kind of election that occurs with many employers. People don't have a coverage problem.

People have coverage it's automatic. It's not an election the individual makes.

We are different in other ways—we are not different in other ways in the service industries. Access to the coverage and funds is very similar, to wit, the commercial insurance. Again there seems to be very low turnover of our membership in the funds even in the service industries, but there is some there again. It is still not a problem. The funds I know that do not have a preexisting condition exclusion, in fact, are in the service industry. Something that may be of interest to you on this issue, I will shed some light.

We had a recent study done of our membership, all the coalition funds membership by our data analysis firm. And for a 12-month period our funds spent $1.3 million on medical treatments directly and specifically identified as related to members with diabetes. Members and their dependents with diabetes. The fascinating thing was when we looked at other comorbidities over that 12-month period, we were 13 million essentially a 10 to 1 ratio. What we found fascinating those comorbidities covered the full range almost every body organ or problem there could be. It strikes me that it's impossible to identify and exclude things that could be related to a particular illness, a chronic disease that are being paid for already. So my point is that the existing exclusions are really only touching a piece of it and why do that? It's so arbitrary as to be patently unfair.

Thank you.

[The statement of Mr. Tessier follows:]

Prepared Statement of Robert Tessier, Executive Director, Connecticut Coalition of the Taft-Hartley Health Fund

On behalf of The Connecticut Coalition of Taft-Hartley Health Funds, Inc. ("Coalition") and its members, I am writing to express my support for H.R. 2833, the "Pre-existing Exclusion Patient Protection Act of 2007." Before I go any further, allow me to share some background information regarding the Coalition and its members that may be helpful.

The Coalition is a non-stock membership corporation under Connecticut law, and it is operated on a "not-for-profit" basis. The Coalition was incorporated in June of 1992, and the Internal Revenue Service has confirmed that the Coalition is a tax-exempt organization under Section 501(c)(6) (business league) of the Internal Revenue Code ("Code"). In general, the Coalition's members are tax-exempt, multi-employer health and welfare funds which are governed by various federal laws, including ERISA and the Taft-Hartley Act of 1947. Each of these Coalition member funds has an affiliation with a specific labor union, and each is normally tax-exempt under Code §501(c)(9) as a "voluntary employees' beneficiary association" or VEBA.

The Coalition currently has seventeen member health funds, the vast number of which are located in Connecticut and cover Connecticut residents. I would estimate that Taft-Hartley Health Funds—the majority of which are Coalition's members—represent approximately 200,000 total covered lives in the state, consisting of active employees, retired individuals and their eligible dependents.

On a personal level, I have extensive experience with labor unions and their associated employee benefits plans. Prior to becoming the Coalition's Executive Director in January of this year, I was the plan administrator of the Connecticut Carpenters Benefit Funds for five years and the New England Health Care Employees Benefit Funds for eight years. I was also the Coalition's President from 2000 through 2007.

Coalition funds are established and funded pursuant to the terms of collective bargaining agreements negotiated by the sponsoring unions and respective employers and/or employer groups. The individual health funds are independently managed and the plan of benefits for each fund is established by their board of trustees. They provide comprehensive health coverage and often include non-health benefits such as life insurance, disability and scholarship benefits. These not-for-profit health funds are unique in the health care marketplace in that they are both payor and consumer. Under federal law (ERISA) these funds exist for the sole and exclusive benefit of the participants and my experience is that when the funds are able to achieve savings, those savings are returned to the participants in the form of increased or improved benefits.

Taken together, Coalition member funds represent the second largest purchaser of health care services in Connecticut, after state government. Member funds spend approximately $100 million on health care services each year. The Coalition's mission is to use the combined strengths of our members to secure the best possible health care at the lowest practical cost. Through various joint-purchasing initiatives we have succeeded in saving our member funds millions of dollars every year. We've established positive relationships throughout the industry and helped stabilize the volatile and escalating costs of health care for both our members and their employers.

Some Coalition member funds do have pre-existing condition exclusion provisions in their plans and some do. Some funds had these exclusions and subsequently eliminated them in the interest of offering equal coverage to all participants. Funds that have such exclusions have indicated that denials of claims for this reason are rare occurrences. To the extent that our funds have members who are medically compromised, i.e. who are denied coverage because of a preexisting condition, those members may represent a safety hazard to co-workers on the job, especially in the construction industry.

While there may be some costs associated with shortening the amount of time that an employer could exclude coverage and shortening the permitted "look-back" period, surely the benefits of increasing access to health insurance coverage outweigh such costs. For these reasons, the Coalition supports the "Pre-existing Exclusion Patient Protection Act of 2007" (H.R. 2833) and urges its passage.

Chairman ANDREWS. Thank you. That is a point of view I had not thought about, that body of evidence. That is very interesting.

Mr. Farrell, welcome to the subcommittee.

STATEMENT OF JOHN FARRELL, FOUNDER, J.J. FARRELL ASSOCIATES

Mr. FARRELL. Thank you, Mr. Chairman and Mr. Courtney. I would like to support H.R. 2833. I think the bill helps protect patients whose clinical and financial condition is compromised. It reduces the cost shift to those with private insurance. It will also as well limit the broad latitude often exercised by health insurers in denying benefits under the umbrella of a preexisting condition.

My comments today will focus on the financial aspects of this issue. Really using the Connecticut health delivery system as an example.

It's not uncommon for people with chronic medical conditions to also experience a deterioration in their financial well-being. When one enters that situation, there are two possibilities. Either care is postponed or denied, or they seek immediate healthcare. In this case it's the hospital delivery system which renders that care.

In Connecticut it is essentially a non-profit community-based delivery system with 31 hospitals. There is no government hospital system.

It is very important for us in this State and in a study we did about three years ago for the Universal Health Care Foundation of Connecticut, we showed 12 percent of hospital costs are shifted from those who cannot pay, that goes right to the insurers. As you're looking for real examples here I will give you an example of our largest employer which is the State of Connecticut. The State of Connecticut pays in excess of $800 million dollars a year for healthcare. Three percent represents a subsidy of those that can't pay. As we look at this mostly through those insurance cross-subsidies there are also other subsidies in this State, there are distressed hospital pools funded out of Federal levels. One starts to look at exactly what we are talking about. There is a reimbursement system today. It is a convoluted system. It's insufficient and ineffective. When that patient does receive care through the emergency room, their outcome is compromised from the beginning. The emergency room is a poor place to receive health care other than in a tragic accident. We did studies that show for a major cancer center in an emergency setting that person's outcome is compromised. I look at that as a very significant issue for us.

As we also look at the individual market, the effects of that, I think it is important to recognize now other facts. The individual market is a community rated market. It's not my direct experience. We wonder why our rates are going up 20 percent. Nobody got sick last year. There is very little choice for the small employer today.

As you look at that, I think that is very important to recognize in this. I think the effort selection is overrated.

Again I support this bill very much. I think it is a constructive first step as you look at this.

[The statement of Mr. Farrell follows:]

Prepared Statement of John J. Farrell, Founder, J.J. Farrell Associates

I would like to thank you for the opportunity to note my support for H.R. 2833. This bill helps protect patients whose clinical condition has compromised both their medical and financial well-being. I believe this bill will reduce the cost shift to those with private insurance. It will also limit the broad latitude often exercised by health

insurers in denying benefits under the umbrella of a pre-existing condition, with minimum additional financial impact upon private payers.

My comments will be from a financing perspective using the Connecticut health delivery system as an example.

It is not uncommon for people with chronic medical conditions to also experience a deterioration of their personal financial resources. In addition, the physical and logistic demands their medical condition makes it harder to maintain consistent employment.

To appreciate the financial impact of HR 2833, I believe it would be helpful to view the issue from an individual's perspective. What happens, for example, when a new employee with a preexisting chronic condition, without health insurance is in need of care?

The answer is straight forward, they either postpone care until coverage begins, or they seek immediate care. If they choose the former option, the employer ultimately picks up the expense, now possibly increased by the cost of complications. More likely they seek care, without the financial resources to pay the full cost of care.

The Cost Shift

In Connecticut, the health care delivery system is anchored by 31 acute care hospitals. It is essentially a non profit community based delivery system. Each hospital, functions as a safety net, caring for all patients irrespective of their coverage status, including the indigent and uninsured. This system, while under mounting pressure, works relatively well when compared to other states.

The health facility rendering this uncompensated care shifts this unmet cost to private payers, including self insured employer groups. This is commonly referred to as the "cost shift". Approximately 12 % of each hospital bill is attributable to the cost shift.

While HR2833 would increase the amount directly paid by the health insurer, it would correspondingly reduce the amount of cost shift. On a net basis there would be little additional cost.

Development of Health Insurance Premiums

It should also be noted that the aggregate health care experience of a population is utilized in the establishment of community health insurance rates. In simple terms the experience of the previous period is used to set prospective rates. The historic expense of caring for chronically ill patients are included in the aggregate plan wide costs. These costs are spread among the broader population and every party paying community rates effectively absorbs a portion of this cost.

Thank you for this opportunity to provide the committee with my views on this important legislation.

Chairman ANDREWS. Thank you. I think it is true the issue is how we are paying and who is paying, not whether we are paying. These costs are being absorbed by the system. The question is whether they are being absorbed in a rational, efficient way, or irrational inefficient way. I would like to ask my friend and colleague if he would like to question the panel first. There is no trap door.

Mr. COURTNEY. Thank you, Mr. Chairman and the witnesses for all their thoughtful testimony here today. I want to start off some of the questions. I am sure the Chairman will jump in as well. Starting with you, Ms. Davenport.

Can you describe the foundation—what kind of people are looking for help from your organization maybe just you don't have to do an exact case study, but a typical person that you're helping and how they pump up into this problem.

Ms. DAVENPORT-ENNIS. Let me take the calendar year of 2007 when we had 6.8 million people in America who reached out to us. They had been diagnosis with a chronic debilitating, life-threatening issue. They were facing obstacles to access, prescribed health care. It was not able to be resolved in their local community, sometimes not even at their State level.

Eighty percent of those people were in some form of insurance. They may have been underinsured, but they were in some form of insurance. Twenty percent were completely uninsured. When we started peeling the layers back to see why are you uninsured, what brought you to this point, why you need us today, what we saw we saw families that had been forced to leave one job in one community and move to another location. Often to take care of a senior family member, so they get to the new location, they are trying to buy insurance for their family. They have a seven-year old son who has chronic asthma. Every plan they try to get into, some said there will be a 12 month pre-ex for this child with asthma, or the family has a situation where the husband is insured. The husband goes in for an examination and is told you're healthy as can be.

That is in 2005. In 2006 he decided he wants to improve his insurance policy. And so he went back to this health insurer, he upgraded it, improved it. Six months later he went to a doctor, he had a strange place on his tongue only to find six months after that that it was a squamous cell carcinoma. Within four months after the diagnosis he received a letter saying we are going to rescind your coverage. You didn't correctly fill out your application to start with.

You had a preexisting condition. There is nothing in his health records or examination that could have suggested to him in 2006 he had preexisting condition. The people who come to us, some of them are in financially desperate conditions. About 16 percent of the uninsured that come to us are at the Federal poverty level or below.

Then you had another slice, the next 30 percent, are still in a low/middle income or upper low range of income, but they have been hit with a diagnosis of life threatening illness, there is no recourse for them. When we try to get them into Medicaid sometimes they are over the limit, they can't qualify, we go to the State high-risk pools. We can't get them enrolled there. So the patients come to us with a number of different issues always in play. Pre-ex ultimately even if we can find an insurance plan for them ends up being the Achilles heel, having genuine insurance.

What happened to the 31 year old woman in Texas? We got her into the Health Insurance Plans, but if she relapses there is not going to be any benefit. Our plan at end of the day, who does she have insurance with. One in three Americans live with probably the same thing. A suggestion to all of us, no matter what we have to forego, we have to get insurance. I hope that gives you some insight as to who is calling us.

Mr. COURTNEY. You talked about cancer patients. Are there other sort of large types of illnesses or conditions that you see a lot of? I guess, there are other chronic conditions.

Ms. DAVENPORT-ENNIS. We do. We serve every chronic debilitating and life-threatening condition in the country. You go to large pockets, anyone who's had a cardiac condition diagnosed even if it is as simple as a prolapsed valve, they are on medications, run five miles a day, healthy. If they have to leave the insurance policy they are in now and try to get insurance in another policy that becomes a preexisting condition.

We have a lot of Americans that have kidney disease even before they are moving into dialysis, even when it is a diagnosis. If they try to get insurance, leaving the insurance they are in can be extremely difficult. You look at patients that have Parkinsons and HIV-AIDS even if they are not actively in the process of advanced disease and the disease is being controlled with medication, if they try to move from one job to another they are locked in. They are not going to get in another policy without preexisting condition.

One of the things I would say to you on behalf of every one we served, for young Americans who really want to start a business maybe they have already been in business, for these if they are diagnosed with a preexisting condition many of those dreams are dashed. They can't find insurance in the individual market. They are not going to be in the group market if they are starting a new company as a rule. So often we see people that have been in business for themselves. They have had to go out of business, become employed by an employer that is large enough they take all comers. They may have a pre-ex period for them or they simply can't make the change.

Mr. COURTNEY. Thank you. Mr. Stirling, I want to follow-up on one of your observations. I think Bob echoed it to a degree.

Just because there is the HIPAA pre-ex time period that exists under Federal law, that doesn't necessarily mean employers or Taft Hartleys or groups have necessarily exercised their rights to use it. Maybe—obviously there is going to be a debate here about whether or not this law is going to be just totally unaffordable or upset the market in a way that is too large a ripple effect covered by other insurance. We do have some real life experiences where people don't use it and are still able to function. Could you follow-up?

Mr. STIRLING. It was our experience in 1996 when HIPAA came out, about half our group plans dropped their preexisting clause. Part of the reason there was a big debate about HIPAA getting one bite of the apple. If you didn't have a great 63 days, there was no preexisting condition carried forward. Only if you didn't have continuous coverage up to that point. Back to that point in the debate if you go back 10-12 years ago. That was a huge change in the industry. But it hasn't eroded the ability of employers to offer plans. There are a lot of things that have driven up costs. This may have been one. This might be a very thin slice of the pie. Half dropped their preexisting condition. In the ensuing 12 years another half dropped. Only about a quarter of plans we administer as a third-party administrator still have preexisting condition. If this law passes the rest will drop. There still would be a thin slice of the pie. Employers want to provide benefits to their employees. They don't like the fact Bob and Sally, Bob sitting next to her, Bob has coverage, Sally doesn't. In the group market this will not have an earth shattering effect.

Mr. COURTNEY. Ms. Horoschak, I want to thank you for your testimony today. When I was working in this building the Connecticut Risk Pool was something we spent a lot of time working on in the mid 1990s, the last wave of health care reform plan was going on. What I am trying to understand again—I want to say AHIP stepping forward saying they want to work on this issue, I think is a very positive thing and I really appreciate that is a contribution

that will, as Mr. Anderson said, something we can work together on. What I am trying to understand, the Guarantee Access Plans you would have administered by the States, is this really just extending to the other 16 States that don't have a risk pool or do you see it different than the risk pools operating now in approximately 30 States?

Ms. HOROSCHAK. I think we view this as qualitatively different. There are two reasons for that. The first is most high-risk pools today don't have the kind of qualification and eligibility requirement we are talking about. That is to say they only accept the individual with the highest health care costs. So we would have the Guarantee Access Plan only cover those individuals who have 200 percent or more of average claim costs. And if a person doesn't get coverage in the private market and goes to the Guarantee Access Plan and makes an application, doesn't have high enough costs then they go back to the private market where they get a guaranteed issued policy. So that is how it works.

The second thing that I think is qualitatively different than the way many high-risk pools operate today, we expect the insurers, private market insurers to provide more assistance to individuals to apply to their Guarantee Access Plan. One of the other things we hear, it is very difficult to apply to the high-risk pool and the agents are not as willing as they might be because there are very limited fees paid for that assistance. Our approach, if the individual requests and of course, the individual plan gets the individual's consent, they would assist the individual with the application process.

Mr. COURTNEY. Would you sort of visualize again each State on a State-by-State basis would have to implement this proposal?

Ms. HOROSCHAK. The way our members decide on the approach was to, of course, look to those States that don't have a high-risk pool to begin with. That would be the starting point. But beyond that to also look at States that currently have high-risk pools and have those either amended or in some way altered to incorporate the new features we are talking about. Then of course, perhaps, in a State like Florida where their high-risk pool was in effect since the early 1990s as mentioned earlier.

Chairman ANDREWS. I would like to thank everyone on the panel for their testimony. We will try to get into couple of specific fact patterns we are talking about today.

Let's say, we have a person working for Bank A, she leaves the bank she gets a job at Bank B. She is now a new employee. Three months prior to starting employment with Bank B she is diagnosed with Type II diabetes. As I understand the law today is that Bank B can decline including her in their health insurance plan for a year. Does anyone disagree with that? Mr. Stirling, what does the law say?

Mr. STIRLING. It depends on facts and circumstances of that transition from Employer A to Employer B. Under the current HIPAA requirements if she was continuously employed at Bank A for more than 12 months and if when she went to Bank B she had a break of no more than 63 days from when she left A went to B, when B picks her up B would be prohibited——

Chairman ANDREWS. Let's say, she had a 70-day break.

Mr. STIRLING. They would look back and say how many months was she continuously covered in Bank A. We would look back, offset the amount of preexisting limitations .

Chairman ANDREWS. What if the preexisting condition manifested itself after she started working for Bank B.

Mr. STIRLING. No, it would look back to see if she has a preexisting condition. But the preexisting condition would be offset by those months that she worked for Bank A.

Chairman ANDREWS. So that would go towards the 12-month window?

Mr. STIRLING. Yes, sir.

Chairman ANDREWS. How come it didn't help Ms. Gould?

Mr. STIRLING. You were looking for an individual policy at that point.

Ms. GOULD. I was looking for coverage for a six-month period after I was no longer eligible on COBRA through United Technologies.

Chairman ANDREWS. Ms. Gould was under a private sector plan through her spouse. She tries to enroll in the AARP plan. She was unable to do so because of her diabetic condition.

Ms. GOULD. I would like to add when it became time for me to select a medicare supplement, AARP was one of the many companies beating down my door to get my premium money. Why? If they didn't want me six months prior, why are they wanting me now?

Chairman ANDREWS. I would suggest there was a significant flaw in Medicare Part B that Mr. Courtney is not responsible for nor I. I want to ask Ms. Horoschak about how we would address the kind of problem we have here today. The first is the Guarantee Access Plan. The State Guarantee Access Plans simply offer a premium. There is no subsidy built into it. What, perhaps, to a person in Connecticut the data in your testimony indicates the individual market premium is $3,326. In my State it's $5,326. If someone is offered insurance under the Guarantee Access Plan that doesn't necessarily mean they get it, does it?

Ms. HOROSCHAK. Obviously, you put your finger on a very important issue which is affordability. That is why our proposal has two different subsidies. One is low and moderate individuals up to 300 percent of the Federal poverty level considering up to 400 of FPL. Second subsidy——

Chairman ANDREWS. How much would that subsidy be worth to a person in Connecticut? Let's say, single person. It wouldn't be $3,300 because Ms. Davenport's testimony indicates it would be 125 or 150 percent of that. What about a single person in Connecticut that's facing a $4,000 premium? How much would that subsidy that you're proposing be worth to them?

Ms. HOROSCHAK. We have not established specifics as to amounts. We have talked about a sliding scale subsidy then an additional subsidy.

Chairman ANDREWS. Where would the money come from for the subsidy?

Ms. HOROSCHAK. We always call from broad-based funding. We would work with other stakeholders to work out what that is.

Chairman ANDREWS. I think people in this room understand far better than I do, the State budget should come up with the subsidy. It's not a Federal subsidy that you're proposing.

Ms. HOROSCHAK. No. Although we support Federal dollars to assist the States with high-risk pools and Guarantee Access.

Chairman ANDREWS. I think the proposal is well thought out, well-intentioned. States are facing fiscal problems. There is a rare governor that would take on new obligations. I think the Connecticut legislators would echo that. So I would think that the hope of a subsidy is not terribly well-founded. People would simply have the right to buy a premium they can't afford. Which doesn't solve the problem.

I want to ask you about the administrative changes that you're proposing that I think have some merit. If there were full disclosure prior to someone taking employment as I understand it, full and complete disclosure, are you proposing that the look back would be abolished? What are you proposing? Someone comes clean with their entire medical record before they start working with the employer, what are you proposing?

Ms. HOROSCHAK. That particular portion is limited to the individual market where the application process is a little bit more important. Because you can't be turned down coverage in a group insurance——

Chairman ANDREWS. If an application was proposed, would you support the same change for the group market?

Ms. HOROSCHAK. I don't see the two as analogous. Right now people don't fill out the long type of application that is required for an individual policy. So our proposal was intended to get at that process if the application—we would require ourselves, so to speak, to have a clear and understandable application. If a person gives all the answers in a complete and accurate way and we furnish them a policy then we don't have a right to impose a preexisting——

Chairman ANDREWS. I understand that. I also understand the significant majority of Americans get their insurance through employers, therefore, your proposal is not really relevant to them, is it?

Ms. HOROSCHAK. That particular portion is not.

Chairman ANDREWS. If I understand Mr. Courtney's bill it is a lot more concise. I think what it says if you're one of the people caught in the the trap of this preexisting condition world, three months is it. That is it. It is sort of a three-month period where you're sort of new to the job. We don't want to disenroll people in a hurry. That is it. Three months you're covered.

If I understand Mr. Courtney's proposal, also the look back period is significantly shortened as well. So—look, one of the witnesses I think said it very well. I think it was Mr. Stirling, there will be costs. There is no free lunch here. If the individuals that Mr. Courtney's plan would protect are protected, someone is going to pay for it. It would be in the form of premiums spread throughout the health care system or wages, what have you. I think that the cost is so relatively small and the payers are so relatively large, that is the fairest way to do this. I think Mr. Courtney's way is the fairest way.

I think we have had alternatives offered in good faith. That is how you get legislation passed.

I am appreciative of that. I've heard two alternatives, one is we are sorry, you're on your own to pay a guaranteed premium. You can't afford this which shifts the costs to people like Ms. Gould which doesn't work. The other is, well, States should come up with these subsidies, out-of-State income tax, State sales tax at a time when State governments are stretched beyond their max. The prospects for them doing this is zero in most places in the country.

We have a controversy in our State where our governor inherits an enormous budget. One possibility is raise tolls on the Garden State Parkway. Everybody is against that. And a budget raise of a couple million dollars. I don't think there is a person in this room, very few people in the Congress, who would say someone like Ms. Gould shouldn't have health insurance, period. The question is how do you pay for it?

I heard really three options here. Option one is she pays for it out of money she doesn't have. That isn't working. Option two, we Federal legislators say States will. The way we do lot of things like No Child Left Behind and lot of other things. That doesn't work very well either.

Third is to say as often happens, this is a requirement spread among the payments in the health insurance system. It is a modest amount. It would do a lot of good. I think there is a good argument it might pay for itself, the comorbidities that Mr. Tessier talked about, some would be avoided. So I think the third way is the best way. We can't say it is not without costs, but I think as Mr. Stirling said it's probably a pretty minimal cost which is why I think Mr. Courtney's legislation is the right way to go.

Joe, did you have some follow-up questions?

Mr. COURTNEY. Real quick. I wanted to go back to Ms. Davenport. The question discussed earlier who's in and who is out based on calculation of the creditable coverage plan. I saw you kind of reaching for the microphone a little bit in terms the hypothetical Mr. Anderson was posing, Bank A and B. How effective is that creditable coverage reduction of exclusion under the existing law? It's a difficult place for Americans to find themselves in.

In the example of going from Bank A to Bank B at least the employee was going from group to group. Heaven forbid if you got to go from individual to individual market. Because when you're at that point that 63-days comes in your life, you roll to day 64 you don't have creditable coverage. We have 106 professional case managers in the United States who are solving these issues everyday and trying to get insurance for someone that has reached that 63 days of creditable coverage. It is extremely difficult. And normally the only way we are going to get it is to get them into a State high-risk pool, yet we shared that against 48 million uninsured Americans, we have only been successful in getting 180,000 Americans in the State high-risk pools. Our experience is that is not working.

So the 63 days, let me share with you we work with AHIP on a lot of issues. One of the things we did was go over to meet with Carmelo Vaskino and several of her representatives because the 63-day requirement is so important in the lives of people. Many people don't realize it, if you breached day 64 you've jeopardized ev-

erything you worked for. Can we have that 63 period in bold on the front of policies and post cards sent out so the consumer, that way the insured would know what it means to their future. I think when we were examining what happened with HIPAA, I had the privilege of working with Senator Kennedy and Nancy Kasenbaum on that legislation. We sat down. There is a segment that's not going to be addressed here and market you have to look at to try to bring some improvement. Our experience in the example, Mr. Anderson gave is heart wrenching, that breached that 63 period, didn't have enough of creditable coverage to offset that period, offset pre-ex, make sure they are insured.

Chairman ANDREWS. Let me explain how the subcommittee is going to proceed. We are going to call on you, I am sure, for further comment and analysis. The subcommittee is considering some legislation to piecing together the number of legislation that would reduce the number of uninsured. Looking at the lifetime limit whether it should be modified or repealed. I think it should be repealed, but we have to debate it.

Second, is look ERISA waivers. Presently Federal law bars obligation to that. For example, Maryland a few years ago passed a statute that required employers larger than 100,000 employees, who did not insure their employees to contribute to Maryland's Medicaid fund to pay the cost. That was struck down by the Federal courts as a violation of the preemptive provision of the ERISA statute. We are taking a look at that to see if it it should be modified.

Third, I think Mr. Courtney's idea fits that discussion very well because it is a very practical approach to reducing the number of uninsured. The way we work on these things is we try to circulate drafts among both majority, and minority members of our committee. I, for the record, think the minority should be invited to do so. Nothing is going to happen without the minority participation and knowledge.

I wish to extend my appreciation to the participants for their excellent preparation and testimony. We will be calling on you. I did want to thank Joe for taking the lead on this issue. Again it's rare legislators that choose to get into the weeds on something like this. This is not an issue that will get you on the front page of the newspapers. Given the front page, the newspapers in our region, I don't think either one of us wants to be on the front pages in my State, or New York. This is not the kind of issue that gets you a lot of media coverage, but gets people health insurance and to understand it the way Mr. Courtney has is very encouraging. He's educating members of the committee on this.

We will leave the record open for comments.

I have to read this script.

As previously ordered, members will have 14 days to submit additional materials for the hearing record. Any member who issues to the committee follow-up questions in writing or to the witnesses should coordinate with the majority staff within 14 days without objection, that is accepted.

We want to thank our hosts in Connecticut for their hospitality. Joe, we would like to thank you.

The hearing is adjourned.

[Additional submissions by Mr. Courtney follow:]

[Letter from the Connecticut AIDS Resource Coalition follows:]

March 20, 2008.

Hon. JOE COURTNEY,
215 Cannon House Office Building, Washington, DC 20515.

DEAR CONGRESSMAN COURTNEY: The Connecticut AIDS Resource Coalition (CARC) is pleased to sign on in support of H.R 2822. "Pre-existing Condition Exclusion Patient Protection Act of 2007" to ensure that individuals who suffer from chronic, disabling, and life-threatening conditions have access to comprehensive, meaningful, and affordable health insurance coverage.

Incorporated in 1989, CARC is Connecticut's only statewide organization whose sole mission is to ensure that people with HIV/AIDS have the housing and services they need to live their lives in dignity.

Clearly, legislation that eliminates pre-existing condition clauses would be of great benefit to people living with HIV/AIDS. If passed, this landmark legislation would enable people living with HIV/AIDS to access life-saving insurance, thus preventing them from having to rely on public assistance or from becoming so ill that their only option was expensive hospitalizations or other institutions such as nursing homes.

Many people may not change jobs or even attempt employment for fear of being turned down to a pre-existing condition such as HIV/AIDS. Yet, quality coverage is essential for people with HIV/AIDS if they are to maintain any semblance of good health.

We applaud you for taking this bold step and look forward to working with you on this and other issues that impact the lives of people with HIV/AIDS.

Peace,

SHAWN M. LANG,
Director of Public Policy.

[Letter from the Juvenile Diabetes Research Foundation International follows:]

Government Relations
1400 K Street NW, Suite 1212
Washington, DC 20005
t: (202) 371-9746 f: (202) 371-2760

JDRF Juvenile Diabetes Research Foundation International

dedicated to finding a cure

October 23, 2007

The Honorable Joe Courtney
United States House of Representatives
215 Cannon House Office Building
Washington, DC 20515

Dear Representative Courtney:

On behalf of the Juvenile Diabetes Research Foundation International (JDRF), I would like to offer our support for the *Preexisting Condition Exclusion Patient Protection Act of 2007*, (H.R. 2833). Your bill makes it easier for those with chronic illnesses such as juvenile or type 1 diabetes and their families to maintain consistent health insurance coverage in the current marketplace.

As you know, JDRF's mission is to fund research and support policies that move us closer toward our goal of finding a cure for juvenile diabetes and its complications as quickly as possible. Yet, so many families that live with type 1 diabetes face challenges in obtaining or maintaining adequate insurance coverage. H.R. 2833 would shorten the timeframe to exclude coverage for pre-existing conditions from 12 months to three months. It would also allow insurance companies to impose a new pre-existing condition exclusion within a 30-day window rather than a six-month "look back" period and provide more uniformity in individual and group plans, and from state to state.

On behalf of millions of Americans, thank you for your steadfast commitment to addressing the health care needs of those with type 1 diabetes. We appreciate your dedication and vision to prevent gaps in insurance coverage for our nation's expanding population that must deal with chronic illness on a daily basis.

Sincerely,

Lawrence A. Soler
Vice President, Government Relations

[Statement of Jennifer Jaff follows:]

Prepared Statement of Jennifer C. Jaff, Esq.

I want to begin by thanking Representative Courtney for introducing this historic legislation, as well as for convening today's event.

I am Founder and Executive Director of Advocacy for Patients with Chronic Illness, Inc., a 501(c)(3) tax exempt organization that provides free information , advice and advocacy services to patients with chronic illnesses in many areas of law, including health insurance. Because everyone we serve has a chronic illness, every one of them by definition has a pre-existing condition.

We receive several calls a week from patients across the country who want to know how to find health insurance that covers their pre-existing condition.

Because of the Health Insurance Portability and Accountability Act (HIPAA), people with insurance through their employers do have coverage of their pre-existing conditions, although they may have to wait as long as twelve months before coverage kicks in. HIPAA defines a pre-existing condition as one for which medical advice, diagnosis, care or treatment was recommended or received within the six months before the enrollment date in the plan. H.R. 2833 would shorten the duration of the permissible waiting period from twelve months to three months, and the "look-back" period—the period we look to in order to determine whether a condition is pre-existing because treatment was recommended or received during that period—from six months to thirty days.

These are critically important improvements on the status quo, to be sure. However, the most dramatic benefits of this legislation will be felt by people who do not receive health insurance through their employers and who have pre-existing conditions that preclude them from purchasing individual insurance.

Currently, in most states, individual insurance is nearly impossible to obtain if you have a pre-existing condition. Some states have what are called "high risk pools," which are designed for people with chronic illnesses, although many have pre-existing condition waiting periods of up to twelve months. Some states have "guaranteed issue" policies, which are policies that insurers are required to offer if they choose to do business in the state, although in many cases, these plans do not cover pre-existing conditions. Very few states have really good alternatives; some have no alternatives at all.

If you have a pre-existing condition, are self-employed or unemployed, and need health insurance, in most states, you are out of luck. If you are a young adult with a pre-existing condition who no longer can be covered under your parents' policy and you do not have insurance through a job, you are out of luck. If you are unable to work due to your pre-existing condition but you are not yet on Social Security disability and, thus, Medicare, you are out of luck.

While writing this testimony, I heard from the mother of a young boy with Crohn's disease whose father applied for health insurance for the family, and the insurer refuses to cover the young son because he has a pre-existing condition. This child is out of luck, too.

This is not a Connecticut problem; this is a national problem. Its impact on the lives of the chronically ill cannot be underestimated. I get phone calls from people who work, who struggle to stay on top of their mortgage payments, and who cannot afford to go to a doctor because they don't have insurance, and can't get insurance because their employer doesn't offer coverage and their pre-existing condition precludes them from finding an individual plan. People forego medically necessary care every single day in this, the richest country in the world, because they cannot afford to pay for the health care and cannot find insurance that will cover their pre-existing condition.

Nearly half of all uninsureds report having a chronic health condition.

- 1.2 million Americans with diabetes report that they are uninsured, and more than half of these report having an unmet need for health care or prescription drugs.
- 3.6 million Americans report having arthritis-related illnesses but have no health insurance, and again, more than half of these report having an unmet need for health care or prescription drugs.
- More than 1.7 million Americans with heart disease are uninsured, as are 2 million adults with asthma.

As one would expect, the statistics show that the chronically ill do not get the health care they need.

- Nearly 38 percent of chronically ill adults indicate that they have skipped medical treatment or did not fill a prescription, as compared with 22 percent of healthy people.
- Only 20 to 25 percent of diabetics receive critical glucose monitoring tests.
- Two-thirds of patients with high blood pressure receive recommended care.
- Fewer than half of patients with heart disease receive proper medication.
- Fewer than half of schizophrenic patients receive appropriate medication.
- Over 27 percent of the uninsured with chronic conditions report that they have not seen a doctor in 12 months.
- Thirty-eight percent of the chronically ill uninsured lack a usual source of care, and those who do rely less on private doctors (as opposed to clinics) than the insured.
- Almost half of the uninsured chronically ill forego needed medical care or prescription drugs.

In 2003, of the 3 million uninsured chronically ill, 42 percent went without needed care, 65 percent delayed care, and 71 percent failed to get needed prescription drugs, all because of cost concerns.

A great deal of this would be avoided if individual insurance was available to the chronically ill.

To make matters worse, even if you can find an individual policy that will cover your pre-existing condition, your insurer may closely monitor your healthcare usage and retroactively claim that you had a pre-existing condition, taking back any payments they have made on your behalf, leaving you without insurance although you've paid the premium.

We've all read about this happening in California, where it took class action litigation to stop insurers from retroactively cancelling policies. But it happens more often than you may realize.

I had one case in which a woman underwent some community-based psychotherapy and then suffered a traumatic event that resulted in a lengthy psychiatric hospitalization. Although her doctors clearly stated that her hospitalization was triggered by the trauma she endured, the insurer took the position that she had a psychological problem warranting psychotherapy before the traumatic event, so her psychiatric problem was pre-existing and, thus, the hospitalization would not be covered. Although ultimately I succeeded in winning this case, we are one of only two organizations in the entire United States that does free insurance appeals. What happens to the people who don't find me?

I wish I could adequately describe the heartache chronically ill patients suffer when they don't have insurance through work and can't get insurance on their own. People lose their jobs because they forego medical care, and then things spiral downhill from there to the point at which they lose their houses, even their cars. I know every trick in the book—ways to help patients obtain free prescription drugs, free clinics, hospital charity care—if there's a resource out there, I know about it. But nothing takes the place of insurance for a person with a chronic illness.

Those of us who need insurance the most can't get it. H.R. 2833 will change that. It will enable people to get the care they need to stay employed, to remain a contributing member of society. It will eliminate many of the bankruptcies that result from medical debt. It will keep families together in their homes. It will stop punishing people because they got sick.

It's incredibly difficult to be sick in America. We have to coordinate care among our various doctors, keep track of our medications, master laws like ERISA, HIPAA, COBRA, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, fight for our rights in the workplace and in school, all while holding our families together and trying to remain afloat in a sea of medical debt. H.R. 2833 is a dramatic and critical step towards easing the burden on the chronically ill.

On behalf of the thousands of patients we serve, I thank Representative Courtney for taking the lead in this critical effort. Thank you.

[Whereupon, at 3:51 p.m., the subcommittee was adjourned.]